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By: Senators Dorman and Bromwell
Introduced and read first time: January 24, 1997
Assigned to: Finance

Committee Report: Favorable with amendments
Senate action: Adopted
Read second time: March 21, 1997

CHAPTER ____

AN ACT concerning

Community Health Networks

FOR the purpose of requiring community health networks to obtain a license from the Secretary of Health and Mental Hygiene and the Insurance Commissioner prior to contracting with certain persons or offering health care services to enrollees; providing certain exceptions; providing for the purpose of this Act; specifying how certain persons may form a community health network; specifying how a community health network may operate under certain circumstances; specifying the requirements of a community health network under this Act, including actuarial soundness requirements, hold harmless provisions, marketing provisions, and rate filing and contract provisions; specifying the duties and responsibilities of the Secretary and Commissioner under this Act; requiring the Secretary and the Commissioner to adopt certain regulations related to the regulation and operation of community health networks; ~~requiring the Secretary to adopt by regulation a certain complaint system;~~ requiring the Secretary and the Commissioner to adopt certain joint internal procedures; establishing certain penalties; altering a provision of law related to requirements of certain health insurers and other persons for accepting and rejecting certain providers for participation on certain provider panels to include a community health network; altering a certain provision of law relating to medical review committees for the purpose of including a community health network; altering a certain provision of law related to the referral of patients to certain entities for the provision of certain health care services to include a community health network; altering a certain provision of law to include a community health network for purposes of determining whether a person is a third party administrator; altering certain provisions of law to include a community health network for purposes of providing health insurance benefits in the small group market; providing for the application of this Act; defining certain terms; and generally relating to the operation and regulation of community health networks.

BY repealing and reenacting, with amendments,
Article - Insurance
Section 8-301(b)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter 36 of the Acts of the General Assembly of 1995)

BY repealing and reenacting, without amendments,
Article - Insurance
Section 15-112(a)(1) and (b) and 15-1201(a)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY repealing and reenacting, with amendments,
Article - Insurance
Section 15-112(a)(2), 15-116(a), and 15-1201(c) and (f)(1)
Annotated Code of Maryland
(1995 Volume and 1996 Supplement)
(As enacted by Chapter _____ (H.B. 11) of the Acts of the General Assembly of 1997)

BY adding to
Article - Health - General
Section 19-2001 through 19-2026, inclusive, to be under the new subtitle "Subtitle 20. Community Health Networks"
Annotated Code of Maryland
(1994 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, without amendments,
Article - Health Occupations
Section 14-501(a)(1) and (3), (b), (c), and (d)
Annotated Code of Maryland
(1994 Replacement Volume and 1996 Supplement)

BY repealing and reenacting, with amendments,
Article - Health Occupations
Section 1-302(d) and 14-501(a)(2)
Annotated Code of Maryland
(1994 Replacement Volume and 1996 Supplement)

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article - Insurance

8-301.

(b) (1) "Administrator" means a person that, to the extent that the person acting for an insurer or plan sponsor, has:

(i) control over or custody of premiums, contributions, or any other money with respect to a plan, for any period of time; or

(ii) discretionary authority over the adjustment, payment, or settlement of benefit claims under a plan or over the investment of a plan's assets.

(2) "Administrator" does not include a person that:

(i) with respect to a particular plan:

1. is, or is an employee of, the plan sponsor;

2. is, or is an employee, agent, or managing general agent of, an insurer [or], health maintenance organization, OR COMMUNITY HEALTH NETWORK that insures or administers the plan; or

3. is a broker that solicits, procures, or negotiates a plan for a plan sponsor and that has no authority over the adjustment, payment, or settlement of benefit claims under the plan or over the investment or handling of the plan's assets;

(ii) is retained by the Life and Health Insurance Guaranty Corporation to administer a plan underwritten by an impaired insurer that is subject to an order of conservation, liquidation, or rehabilitation;

(iii) is a participant or beneficiary of a plan that provides for individual accounts and allows a participant or beneficiary to exercise investment control over assets in the participant's or beneficiary's account, and the participant or beneficiary exercises that investment control;

(iv) administers only plans that are subject to ERISA and that do not provide benefits through insurance, unless any of the plans administered is a multiple employer welfare arrangement as defined in § 514(b)(6)(A)(ii) of ERISA;

(v) is, or is an employee of, a bank, savings bank, trust company, savings and loan association, or credit union that is regulated under the laws of this State, another state, or the United States; or

(vi) is, or is an employee of, a person that is registered as:

1. an investment adviser under the Investment Advisers Act of 1940 or the Maryland Securities Act;

2. a broker-dealer or transfer agent under the Securities Exchange Act of 1934 or the Maryland Securities Act; or

3. an investment company under the Investment Company Act of 1940.

15-112.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Carrier" means:

1. an insurer;

2. a nonprofit health service plan;

3. a health maintenance organization;

4. a dental plan organization; [or]

5. A COMMUNITY HEALTH NETWORK, AS DEFINED UNDER § 19-2001 OF THE HEALTH - GENERAL ARTICLE; OR

[5.] 6. any other person that provides health benefit plans subject to regulation by the State.

(ii) "Carrier" includes an entity that arranges a provider panel for a carrier.

(b) A carrier that uses a provider panel shall establish procedures to:

(1) review applications for participation on the carrier's provider panel in accordance with this section;

(2) notify an enrollee of:

(i) the termination from the carrier's provider panel of the primary care provider that was furnishing health care services to the enrollee; and

(ii) the right of the enrollee, on request, to continue to receive health care services from the enrollee's primary care provider for up to 90 days after the date of the notice of termination of the enrollee's primary care provider from the carrier's provider panel, if the termination was for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status;

(3) notify primary care providers on the carrier's provider panel of the termination of a specialty referral services provider; and

(4) notify a provider at least 90 days before the date of the termination of the provider from the carrier's provider panel, if the termination is for reasons unrelated to fraud, patient abuse, incompetency, or loss of licensure status.

15-116.

(a) (1) In this section the following words have the meanings indicated.

(2) "Carrier" means:

(i) an insurer;

(ii) a nonprofit health service plan;

(iii) a health maintenance organization;

(iv) a dental plan organization; [or]

(V) A COMMUNITY HEALTH NETWORK, AS DEFINED UNDER § 19-2001 OF THE HEALTH - GENERAL ARTICLE; OR

[(v)] (VI) any other person that provides health benefit plans subject to regulation by the State.

(3) "Health care provider" means an individual who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

15-1201.

(a) In this subtitle the following words have the meanings indicated.

(c) "Carrier" means a person that:

(1) offers health benefit plans in the State covering eligible employees of small employers; and

(2) is:

(i) an authorized insurer that provides health insurance in the State;

(ii) a nonprofit health service plan that is licensed to operate in the State;

(iii) a health maintenance organization that is licensed to operate in the State; [or]

(IV) A COMMUNITY HEALTH NETWORK THAT IS LICENSED TO OPERATE IN THE STATE; OR

[(iv)] (V) any other person or organization that provides health benefit plans subject to State insurance regulation.

(f) (1) "Health benefit plan" means:

(i) a policy or certificate for hospital or medical benefits;

(ii) a nonprofit health service plan; [or]

(iii) a health maintenance organization subscriber or group master contract; OR

(IV) A COMMUNITY HEALTH NETWORK.

Article - Health - General

SUBTITLE 20. COMMUNITY HEALTH NETWORKS.

19-2001. DEFINITIONS.

(A) IN THIS SUBTITLE THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(B) "ADMINISTRATION" MEANS THE MARYLAND INSURANCE ADMINISTRATION.

(C) "AFFILIATED HEALTH CARE PROVIDERS OR AFFILIATED GROUPS OF HEALTH CARE PROVIDERS" MEANS THOSE HEALTH CARE PROVIDERS THAT:

(1) ARE UNDER THE COMMON CONTROL AND OWNERSHIP OF A COMMUNITY HEALTH NETWORK; OR

(2) HAVE ENTERED INTO CONTRACTUAL RELATIONSHIPS WITHIN A COMMUNITY HEALTH NETWORK WHERE THE HEALTH CARE PROVIDERS SHARE SUBSTANTIAL FINANCIAL RISK.

(D) "COMMISSIONER" MEANS THE STATE INSURANCE COMMISSIONER.

(E) "COMMUNITY HEALTH NETWORK" MEANS AN ENTITY THAT:

(1) IS A LEGAL AGGREGATION OF HEALTH CARE PROVIDERS OPERATING COLLECTIVELY FOR THE PURPOSE OF PROVIDING HEALTH CARE SERVICES TO A DEFINED POPULATION ON A PREPAID OR FIXED PAYMENT PER TIME PERIOD BASIS;

(2) ACTS THROUGH A LICENSED ENTITY, SUCH AS A PARTNERSHIP, CORPORATION, OR SOLE PROPRIETORSHIP, THAT HAS AUTHORITY OVER THE ENTITY'S ACTIVITIES AND RESPONSIBILITY FOR SATISFYING THE REQUIREMENTS OF THIS SUBTITLE;

(3) PROVIDES AT LEAST ~~65%~~ A MAJORITY OF THE HEALTH CARE SERVICES REQUIRED UNDER CONTRACT WITH A PURCHASER DIRECTLY THROUGH ~~A HEALTH CARE PROVIDER~~ HEALTH CARE PROVIDERS THAT OWN AND CONTROL THE COMMUNITY HEALTH NETWORK, AFFILIATED HEALTH CARE PROVIDERS, OR AFFILIATED GROUPS OF HEALTH CARE PROVIDERS; AND

(4) PROVIDES OR ARRANGES FOR THE PROVISION OF:

~~(I) A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES AS REQUIRED UNDER:~~

(I) THE SAME BENEFITS FOR HEALTH CARE SERVICES, INCLUDING ALL LEVELS OF BENEFITS AND REQUIRED OFFERINGS OF BENEFITS, AS REQUIRED UNDER:

1. TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE WHEN OPERATING IN THE SMALL GROUP MARKET;

2. TITLE 19, SUBTITLE 7 OF THIS ARTICLE FOR HEALTH MAINTENANCE ORGANIZATIONS WHEN OPERATING IN THE COMMERCIAL MARKET; OR

3. THE FEDERAL MEDICARE PROGRAM WHEN OPERATING UNDER A RISK CONTRACT WITH THE MEDICARE PROGRAM; OR

(II) A LIMITED SET OF INTEGRATED HEALTH CARE SERVICES FOR INDIVIDUALS ENROLLED IN A GOVERNMENTAL PROGRAM TO PROVIDE HEALTH CARE SERVICES TO LOW INCOME INDIVIDUALS WHO ARE UNINSURED OR UNDERINSURED.

(F) "ENROLLEE" MEANS AN INDIVIDUAL, INCLUDING A MEMBER OF A GROUP, TO WHOM A COMMUNITY HEALTH NETWORK IS OBLIGATED TO PROVIDE HEALTH CARE SERVICES IN ACCORDANCE WITH THIS SUBTITLE.

(G) "HEALTH CARE PROVIDER" MEANS:

(1) AN INDIVIDUAL WHO IS LICENSED, CERTIFIED, OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES IN THE ORDINARY COURSE OF BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM;

(2) A HEALTH CARE FACILITY, AS DEFINED IN § 19-101 OF THIS TITLE, WHERE HEALTH CARE SERVICES ARE PROVIDED TO PATIENTS, INCLUDING AN OUTPATIENT CLINIC AND A MEDICAL LABORATORY; OR

(3) A FEDERALLY OR STATE QUALIFIED COMMUNITY HEALTH CENTER.

(H) (1) "HEALTH CARE SERVICES" MEANS SERVICES, MEDICAL EQUIPMENT, AND SUPPLIES THAT ARE PROVIDED BY A HEALTH CARE PROVIDER.

(2) "HEALTH CARE SERVICES" INCLUDES:

(I) AMBULANCE SERVICES;

(II) APPLIANCES, DRUGS, MEDICINES, AND SUPPLIES;

(III) AUDIOLOGIC CARE AND SERVICES;

(IV) CHIROPRACTIC CARE AND SERVICES;

(V) CONVALESCENT INSTITUTIONAL CARE;

(VI) DENTAL CARE AND SERVICES;

(VII) EXTENDED CARE;

(VIII) FAMILY PLANNING OR INFERTILITY SERVICES;

(IX) HEALTH EDUCATION SERVICES;

(X) HOME HEALTH CARE OR MEDICAL SOCIAL SERVICES;

(XI) HOSPICE SERVICES;

(XII) INPATIENT HOSPITAL SERVICES;

(XIII) LABORATORY, RADIOLOGICAL, OR OTHER DIAGNOSTIC SERVICES;

(XIV) MARRIAGE AND FAMILY THERAPY;

(XV) MEDICAL CARE AND SERVICES;

(XVI) MEDICAL NUTRITION THERAPY;

(XVII) MENTAL HEALTH SERVICES;

(XVIII) NURSING CARE AND SERVICES;

(XIX) NURSING HOME CARE;

(XX) OPTICAL CARE AND SERVICES;

(XXI) OPTOMETRIC CARE AND SERVICES;

(XXII) OSTEOPATHIC CARE AND SERVICES;

(XXIII) OUTPATIENT SERVICES;

(XXIV) PHARMACEUTICAL SERVICES;

(XXV) PHYSICAL THERAPY CARE AND SERVICES;

(XXVI) PODIATRIC CARE AND SERVICES;

(XXVII) PREVENTIVE MEDICAL SERVICES;

(XXVIII) PSYCHOLOGICAL CARE AND SERVICES;

(XXIX) REHABILITATIVE SERVICES;

(XXX) SPEECH PATHOLOGY SERVICES;

(XXXI) SURGICAL CARE AND SERVICES;

(XXXII) TREATMENT FOR ALCOHOLISM OR DRUG ABUSE; AND

(XXXIII) ANY OTHER CARE, SERVICE, OR TREATMENT OF DISEASE OR INJURY, THE CORRECTION OF DEFECTS, OR THE MAINTENANCE OF THE PHYSICAL AND MENTAL WELL-BEING OF HUMAN BEINGS.

(I) "PAYOR" MEANS:

(1) AN INSURER, NONPROFIT HEALTH SERVICE PLAN, OR HEALTH MAINTENANCE ORGANIZATION THAT HOLDS A CERTIFICATE OF AUTHORITY TO OFFER HEALTH INSURANCE POLICIES OR CONTRACTS IN THE STATE IN ACCORDANCE WITH THIS ARTICLE OR THE INSURANCE ARTICLE; OR

(2) ANY OTHER PERSON OR ORGANIZATION THAT PROVIDES HEALTH BENEFIT PLANS SUBJECT TO STATE INSURANCE REGULATION.

(J) (1) "PURCHASER" MEANS ANY PERSON WITH WHICH A COMMUNITY HEALTH NETWORK DIRECTLY CONTRACTS TO PROVIDE HEALTH CARE SERVICES ON A PREPAID OR FIXED PAYMENT PER TIME PERIOD BASIS TO A DEFINED POPULATION.

(2) "PURCHASER" INCLUDES:

(I) AN INDIVIDUAL;

(II) AN EMPLOYER; OR

(III) A GOVERNMENTAL ENTITY.

19-2002. PURPOSE.

THE PURPOSE OF THIS SUBTITLE IS TO:

(1) FOSTER THE DEVELOPMENT OF COMMUNITY HEALTH NETWORKS THAT WILL BE RESPONSIBLE FOR ARRANGING FOR OR DELIVERING TO A DEFINED POPULATION ON AN INSURED, PREPAID, OR FIXED PRICE BASIS A CONTINUUM OF INTEGRATED HEALTH CARE SERVICES;

(2) ENCOURAGE THE FORMATION OF COMMUNITY HEALTH NETWORKS BY DIVERSE GROUPS WITH A VIEW TOWARD ACHIEVING GREATER EFFICIENCY AND ECONOMY IN PROVIDING HEALTH CARE SERVICES;

(3) ENCOURAGE THE FORMATION OF COMMUNITY HEALTH NETWORKS THAT INCLUDE LOCAL HEALTH CARE PROVIDERS THAT HAVE HISTORICALLY PROVIDED HEALTH CARE SERVICES IN THE COMMUNITY;

(4) PROVIDE ONE OVERALL STATE LAW THAT:

(I) REGULATES COMMUNITY HEALTH NETWORKS;

(II) ALLOWS FLEXIBILITY FOR THE MANY FORMS THAT COMMUNITY HEALTH NETWORKS MAY TAKE; AND

(III) FACILITATES PUBLIC UNDERSTANDING AND UNIFORM ADMINISTRATION OF THE REGULATIONS ADOPTED UNDER THIS SUBTITLE; AND

(5) PROVIDE FOR THE REGULATION:

(I) BY THE DEPARTMENT, OF THE QUALITY AND PUBLIC ACCOUNTABILITY OF HEALTH CARE SERVICES PROVIDED BY COMMUNITY HEALTH NETWORKS; AND

(II) BY THE COMMISSIONER, OF ALL OTHER MATTERS COVERED UNDER THIS SUBTITLE, INCLUDING RESERVES AND FINANCIAL SOLVENCY REQUIREMENTS.

19-2003. SCOPE OF SUBTITLE.

THIS SUBTITLE DOES NOT APPLY TO A NETWORK OF HEALTH CARE PROVIDERS THAT:

(1) IS CONTRACTING DIRECTLY WITH A PURCHASER UNDER A FEE-FOR-SERVICE OR OTHER NONRISK BEARING ARRANGEMENT; OR

(2) IS CONTRACTING DIRECTLY UNDER A CAPITATED OR OTHER RISK-SHARING ARRANGEMENT WITH A PAYOR OR A GOVERNMENTAL ENTITY WHERE THE PAYOR OR THE GOVERNMENTAL ENTITY IS RESPONSIBLE FOR THE FINANCIAL RISK OF PROVIDING HEALTH CARE SERVICES TO ENROLLEES.

19-2004. LICENSURE REQUIREMENT.

(A) EXCEPT AS OTHERWISE PROVIDED IN THIS SUBTITLE, A COMMUNITY HEALTH NETWORK SHALL BE LICENSED JOINTLY BY THE SECRETARY AND THE COMMISSIONER TO OPERATE AS A COMMUNITY HEALTH NETWORK BEFORE IT MAY ENTER INTO ANY CONTRACT WITH A PURCHASER TO PROVIDE HEALTH CARE SERVICES TO A DEFINED POPULATION ON A PREPAID OR FIXED PAYMENT PER TIME PERIOD BASIS.

(B) THE DEPARTMENT SHALL BE THE POINT OF ENTRY FOR A COMMUNITY HEALTH NETWORK SEEKING TO OBTAIN A LICENSE TO OPERATE IN THE STATE AND FOR ENROLLEES AND OTHER PERSONS TO MAKE COMPLAINTS CONCERNING THE OPERATION OF A COMMUNITY HEALTH NETWORK.

(C) (1) THE SECRETARY AND THE COMMISSIONER SHALL ISSUE A LICENSE TO AN APPLICANT THAT MEETS THE REQUIREMENTS OF THIS SUBTITLE AND ALL APPLICABLE REGULATIONS ADOPTED BY THE SECRETARY OR THE COMMISSIONER UNDER THIS SUBTITLE.

(2) A LICENSE MAY NOT BE ISSUED UNLESS BOTH THE SECRETARY AND THE COMMISSIONER CERTIFY THAT THE REQUIREMENTS OF THIS SUBTITLE HAVE BEEN MET.

(D) A LICENSE ISSUED UNDER THIS SUBTITLE IS NOT TRANSFERABLE.

19-2005. ADOPTION OF JOINT INTERNAL PROCEDURES.

(A) THE SECRETARY AND THE COMMISSIONER SHALL ADOPT JOINT INTERNAL PROCEDURES TO ASSIST THEM IN WORKING TOGETHER AND WITH THE HEALTH RESOURCES PLANNING COMMISSION, THE HEALTH SERVICES COST REVIEW COMMISSION, AND THE HEALTH CARE ACCESS AND COST COMMISSION TO CARRY OUT THEIR RESPONSIBILITIES UNDER THIS SUBTITLE.

(B) THE JOINT INTERNAL PROCEDURES SHALL:

(1) ESTABLISH A MEANS BY WHICH THE DEPARTMENT AND THE COMMISSIONER MAY INFORM EACH OTHER PROMPTLY ON MATTERS THAT AFFECT ANY COMMUNITY HEALTH NETWORK, INCLUDING:

(I) ANY IMPORTANT ACTION, CHANGE, OR ARRANGEMENT THAT A COMMUNITY HEALTH NETWORK MAY UNDERTAKE; AND

(II) ANY REGULATORY MATTER; AND

(2) ESTABLISH A MEANS TO COORDINATE AND INTEGRATE THE REGULATION OF THE INDIVIDUAL HEALTH CARE ~~PROVIDER~~ FACILITY COMPONENTS OF COMMUNITY HEALTH NETWORKS.

19-2006. RESPONSIBILITIES OF DEPARTMENT AND COMMISSIONER.

(A) THE SECRETARY SHALL:

(1) BE RESPONSIBLE FOR DETERMINING WHETHER EACH COMMUNITY HEALTH NETWORK IS OR WILL BE ABLE TO COMPLY WITH THE REQUIREMENTS OF THIS SUBTITLE AND REGULATIONS ADOPTED UNDER THIS SUBTITLE REGARDING QUALITY OF CARE AND PUBLIC ACCOUNTABILITY ISSUES; AND

(2) REFER COMPLAINTS REGARDING FINANCIAL SOLVENCY, MARKET CONDUCT, BENEFITS, AND PUBLIC UNDERSTANDING ISSUES TO THE COMMISSIONER FOR INVESTIGATION.

~~(B) (1) THE SECRETARY SHALL ESTABLISH BY REGULATION A COMPLAINT SYSTEM FOR THE RECEIPT AND TIMELY INVESTIGATION OF COMPLAINTS.~~

~~(2) THE COMPLAINT SYSTEM SHALL INCLUDE:~~

~~(I) A PROCEDURE FOR THE TIMELY ACKNOWLEDGMENT OF THE RECEIPT OF A COMPLAINT, INCLUDING ENROLLEE COMPLAINTS; AND~~

~~(II) A PROCEDURE FOR FORWARDING TO THE COMMISSIONER COMPLAINTS CONCERNING FINANCIAL SOLVENCY, MARKET CONDUCT, BENEFITS, AND PUBLIC UNDERSTANDING ISSUES.~~

~~(3) IF A COMPLAINT CONCERNS A HEALTH CARE PROVIDER'S PERFORMANCE OR STANDARDS OF MEDICAL PRACTICE, THE SECRETARY SHALL REFER THE COMPLAINT TO THE BOARD THAT LICENSES, CERTIFIES, OR OTHERWISE AUTHORIZES THAT HEALTH CARE PROVIDER UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE SERVICES.~~

~~(C)~~ (B) THE COMMISSIONER IS RESPONSIBLE FOR:

(1) DETERMINING WHETHER EACH COMMUNITY HEALTH NETWORK IS OR WILL BE ABLE TO PROVIDE A FISCALLY SOUND OPERATION AND ADEQUATE PROVISIONS AGAINST RISK OF INSOLVENCY AND MAY ADOPT REGULATIONS DESIGNED TO ACHIEVE THIS GOAL;

(2) ACTUARIAL AND FINANCIAL EVALUATIONS AND DETERMINATIONS AND RATE REVIEW OF EACH COMMUNITY HEALTH NETWORK; AND

(3) MONITORING THE MARKET CONDUCT ACTIVITIES OF COMMUNITY HEALTH NETWORKS TO AVOID MISREPRESENTATIONS AND CONFUSION AS TO COVERAGE AND BENEFITS BEING OFFERED.

19-2007. REGULATIONS.

~~(A) THE SECRETARY SHALL ADOPT REGULATIONS ON THE FOLLOWING:~~

~~(1) REQUIREMENTS FOR LICENSURE, INCLUDING A FEE FOR AN INITIAL APPLICATION AND AN ANNUAL RENEWAL FEE;~~

~~(2) QUALITY OF CARE STANDARDS;~~

~~(3) REQUIREMENTS REGARDING THE AVAILABILITY OF HEALTH CARE SERVICES; AND~~

~~(4) REQUIREMENTS REGARDING THE DEFINED POPULATION TO BE SERVED BY THE COMMUNITY HEALTH NETWORK.~~

(A) (1) THE SECRETARY MAY ADOPT RULES, REGULATIONS, AND STANDARDS FOR THE QUALITY OF HEALTH CARE SERVICES PROVIDED BY A COMMUNITY HEALTH NETWORK THROUGH ITS BENEFIT PACKAGES.

(2) WITH THE ADVICE OF THE DEPARTMENT, THE COMMISSIONER SHALL ADOPT REASONABLE RULES AND REGULATIONS AS NECESSARY TO CARRY OUT OTHER PROVISIONS OF THIS SUBTITLE NOT RELATED TO THE QUALITY OF HEALTH CARE SERVICES PROVIDED BY A COMMUNITY HEALTH NETWORK.

(B) IN ADDITION TO THE REGULATIONS ADOPTED UNDER SUBSECTION (A)(2) OF THIS SECTION, THE COMMISSIONER SHALL ADOPT REGULATIONS ON THE FOLLOWING:

(1) SETTING AN APPLICATION REVIEW FEE FOR THE REVIEW BY THE COMMISSIONER OF AN INITIAL APPLICATION AND AN ANNUAL RENEWAL REVIEW FEE;

(2) REQUIREMENTS FOR OPEN ENROLLMENT;

(3) PROVISIONS FOR INCENTIVES FOR COMMUNITY HEALTH NETWORKS TO ACCEPT AS ENROLLEES INDIVIDUALS WHO HAVE HIGH RISKS FOR NEEDING HEALTH CARE SERVICES AND INDIVIDUALS AND GROUPS WITH SPECIAL NEEDS;

(4) PROHIBITIONS AGAINST DISENROLLING INDIVIDUALS OR GROUPS WITH HIGH RISKS OR SPECIAL NEEDS;

(5) SUBJECT TO § 19-2012 OF THIS SUBTITLE, REQUIREMENTS FOR FINANCIAL SOLVENCY AND STABILITY;

(6) LIMITS ON COPAYMENTS AND DEDUCTIBLES;

(7) REQUIREMENTS FOR MAINTENANCE AND REPORTING OF INFORMATION ON COSTS, PRICES, REVENUES, VOLUME OF SERVICES, AND OUTCOMES AND QUALITY OF SERVICES;

(8) PROVISIONS FOR APPROPRIATE RISK ADJUSTERS OR OTHER METHODS TO PREVENT OR COMPENSATE FOR ADVERSE SELECTION OF ENROLLEES INTO OR OUT OF A COMMUNITY HEALTH NETWORK; AND

(9) PROVISIONS ESTABLISHING STANDARD MEASURES AND METHODS BY WHICH COMMUNITY HEALTH NETWORKS SHALL DETERMINE AND DISCLOSE

THEIR PRICES, COPAYMENTS, DEDUCTIBLES, OUT-OF-POCKET LIMITS, ENROLLEE SATISFACTION LEVELS, AND ANTICIPATED LOSS RATIOS.

(C) THE SECRETARY AND THE COMMISSIONER SHALL JOINTLY ADOPT REGULATIONS ON PUBLIC UNDERSTANDING ISSUES.

19-2008. BASIC REQUIREMENTS TO OPERATE AS A COMMUNITY HEALTH NETWORK.

(A) A COMMUNITY HEALTH NETWORK MAY BE FORMED, EITHER SINGLY OR IN SOME COMBINATION BY:

(1) HEALTH CARE PROVIDERS;

(2) INSURERS;

(3) NONPROFIT HEALTH SERVICE PLANS;

(4) HEALTH MAINTENANCE ORGANIZATIONS;

(5) EMPLOYERS; OR

(6) ANY OTHER BUSINESS OR LEGAL ENTITIES.

(B) A COMMUNITY HEALTH NETWORK SHALL:

(1) PROVIDE AT LEAST ~~65%~~ A MAJORITY OF THE HEALTH CARE SERVICES REQUIRED UNDER A CONTRACT WITH A PURCHASER IN ACCORDANCE WITH THE PROVISIONS OF THIS SUBTITLE DIRECTLY THROUGH ~~A HEALTH CARE PROVIDER~~ HEALTH CARE PROVIDERS THAT OWN AND CONTROL THE COMMUNITY HEALTH NETWORK, AFFILIATED HEALTH CARE PROVIDERS, OR AFFILIATED GROUPS OF HEALTH CARE PROVIDERS; AND

(2) PROVIDE OR ARRANGE FOR THE PROVISION OF:

~~(I) A FULL RANGE OF INTEGRATED HEALTH CARE SERVICES AS REQUIRED UNDER:~~

(I) THE SAME BENEFITS FOR HEALTH CARE SERVICES, INCLUDING ALL LEVELS OF BENEFITS AND REQUIRED OFFERINGS OF BENEFITS, AS REQUIRED UNDER:

1. TITLE 15, SUBTITLE 12 OF THE INSURANCE ARTICLE WHEN OPERATING IN THE SMALL GROUP MARKET;

2. TITLE 19, SUBTITLE 7 OF THIS ARTICLE FOR HEALTH MAINTENANCE ORGANIZATIONS WHEN OPERATING IN THE COMMERCIAL MARKET; OR

3. THE FEDERAL MEDICARE PROGRAM WHEN OPERATING UNDER A RISK CONTRACT WITH THE MEDICARE PROGRAM; OR

(II) A LIMITED SET OF INTEGRATED HEALTH CARE SERVICES FOR INDIVIDUALS ENROLLED IN A GOVERNMENTAL PROGRAM TO PROVIDE HEALTH CARE SERVICES TO LOW INCOME INDIVIDUALS.

(C) (1) A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE IS NOT ENTITLED TO AN EXEMPTION FROM OTHER PROVISIONS OF LAW RELATING TO:

(I) THE REVIEW AND APPROVAL OF HOSPITAL RATES AND CHARGES BY THE HEALTH SERVICES COST REVIEW COMMISSION; ~~AND~~

(II) THE REVIEW AND APPROVAL OF NEW SERVICES OR FACILITIES BY THE HEALTH RESOURCES PLANNING COMMISSION; AND

(III) THE REQUIREMENTS OF TITLE 7 OF THE INSURANCE ARTICLE.

(2) PARAGRAPH (1) OF THIS SUBSECTION DOES NOT PROHIBIT A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE THAT INCLUDES A HOSPITAL FROM NEGOTIATING A CAPITATION ARRANGEMENT OR PREMIUM FOR THE ENTIRE COMMUNITY HEALTH NETWORK IF THE HOSPITAL CAPITATION ARRANGEMENT HAS BEEN REVIEWED AND APPROVED BY THE HEALTH SERVICES COST REVIEW COMMISSION.

(3) A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE IS SUBJECT TO:

(I) § 19-706 OF THIS TITLE, EXCLUDING ANY REFERENCE IN THAT SECTION TO TITLE 14, SUBTITLE 1 OF THE INSURANCE ARTICLE; AND

(II) §§ 19-710(J) THROUGH (L) AND 19-713.1 OF THIS TITLE.

(D) A COMMUNITY HEALTH NETWORK MAY OPERATE AS AUTHORIZED UNDER THIS SUBTITLE NOTWITHSTANDING ANY PROHIBITION AGAINST THE CORPORATE PRACTICE OF MEDICINE.

19-2009. PUBLIC ACCOUNTABILITY.

(A) (1) EACH COMMUNITY HEALTH NETWORK SHALL ESTABLISH A WRITTEN QUALITY IMPROVEMENT PLAN TO ASSURE THE CONTINUING DELIVERY OF QUALITY HEALTH CARE SERVICES TO ENROLLEES.

(2) THE QUALITY IMPROVEMENT PLAN SHALL:

(I) IDENTIFY THE COMMUNITY HEALTH NETWORK'S HEALTH CARE PRIORITIES AND OBJECTIVES, INCLUDING A DESCRIPTION OF HOW THESE PRIORITIES AND OBJECTIVES RELATING TO THE HEALTH STATUS PROBLEMS AND NEEDS OF ITS ENROLLEES WILL BE PROVIDED FOR;

(II) ESTABLISH AN ONGOING PROCESS FOR ENSURING THAT HEALTH CARE PROVIDERS ARE APPROPRIATELY CREDENTIALED AND THAT HEALTH CARE SERVICES ARE COORDINATED AND PROVIDED TO ENROLLEES IN A TIMELY MANNER;

(III) ESTABLISH PROCEDURES FOR WORKING WITH OTHER EXISTING HEALTH BENEFIT PLANS, LOCAL HEALTH DEPARTMENTS, HEALTH CARE PROVIDERS THAT HAVE HISTORICALLY PROVIDED HEALTH CARE SERVICES WITHIN THE COMMUNITY, AND COMMUNITY ORGANIZATIONS SERVING THE SAME

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COMMUNITY TO DEVELOP AND IMPLEMENT A PROCESS FOR IMPROVING THE HEALTH STATUS OF THE COMMUNITY; AND

(IV) DESCRIBE HOW INFORMATION FROM ANNUAL REPORTS, CONSUMER COMPLAINTS, AND ANY OTHER SOURCE WILL BE USED TO IMPROVE THE QUALITY OF HEALTH CARE SERVICES PROVIDED BY THE COMMUNITY HEALTH NETWORK.

(3) (I) UNLESS THE COMMUNITY HEALTH NETWORK RECEIVES A WAIVER FROM THE DEPARTMENT, THE DEPARTMENT SHALL REVIEW AND APPROVE THE QUALITY IMPROVEMENT PLAN OF EACH COMMUNITY HEALTH NETWORK EVERY 2 YEARS.

(II) THE SECRETARY SHALL ESTABLISH BY REGULATION THE CRITERIA TO BE USED TO DETERMINE IF THE REVIEW OF A COMMUNITY HEALTH NETWORK'S QUALITY IMPROVEMENT PLAN MAY BE WAIVED.

(B) EACH COMMUNITY HEALTH NETWORK SHALL:

(1) WORKING IN CONCERT WITH LOCAL HEALTH DEPARTMENTS AND OTHER APPROPRIATE COMMUNITY ORGANIZATIONS, IDENTIFY SPECIFIC HEALTH PROBLEMS IN THE COMMUNITY IT SERVES;

(2) DEVELOP AN ACTION PLAN THAT IS RESPONSIVE TO AT LEAST ONE OF THE HEALTH PROBLEMS IDENTIFIED THAT INCLUDES:

(I) MEASURABLE OBJECTIVES TO BE ACHIEVED WITHIN A SPECIFIED TIME PERIOD;

(II) WHAT RESOURCES WILL BE USED TO ACHIEVE THE HEALTH OBJECTIVES IDENTIFIED IN THE ACTION PLAN; AND

(III) A PROCESS FOR MEASURING THE RESULTS OF THE ACTION PLAN AND EVALUATING THE RESULTS TO DETERMINE FUTURE GOALS AND OBJECTIVES; AND

(3) PREPARE AND SUBMIT ANNUALLY TO THE SECRETARY A PROGRESS REPORT THAT CONTAINS SPECIFIC OUTCOME MEASUREMENTS THAT MARK ITS PROGRESS IN ADDRESSING:

(I) HEALTH CARE PROBLEMS WITHIN ITS SERVICE AREA AND THE STATE IN GENERAL; AND

(II) HEALTH PRIORITIES AND OBJECTIVES IN THE COMMUNITY.

19-2010.

A COMMUNITY HEALTH NETWORK SHALL BE GOVERNED BY A BOARD OF DIRECTORS THAT:

(1) IS COMPRISED OF A MAJORITY OF MEMBERS WHO ARE MARYLAND RESIDENTS; AND

(2) INCLUDES SIGNIFICANT PARTICIPATION AND REPRESENTATION BY LOCAL PHYSICIANS AND OTHER HEALTH CARE PROVIDERS.

19-2011. DATA REPORTING.

EACH COMMUNITY HEALTH NETWORK SHALL:

(1) REPORT ANY FINANCIAL OR OTHER INFORMATION IN THE FORM REQUIRED BY THE COMMISSIONER BY REGULATION FOR THE PURPOSE OF EVALUATING WHETHER THE COMMUNITY HEALTH NETWORK IS OPERATING IN A FISCALLY SOUND MANNER AND THE REASONABLENESS OF ITS RATES;

(2) PARTICIPATE IN APPROPRIATE QUALITY OF CARE AND PERFORMANCE MEASUREMENT DATA COLLECTION EFFORTS OF THE HEALTH CARE ACCESS AND COST COMMISSION;

(3) REPORT INFORMATION CONSISTENT WITH THE REQUIREMENTS OF THE MARYLAND MEDICAL CARE DATABASE ESTABLISHED UNDER § 19-1507 OF THIS TITLE; ~~AND~~

(4) PARTICIPATE, AS APPROPRIATE, IN THE PAYMENT SYSTEM ESTABLISHED UNDER § 19-1509 OF THIS TITLE AND THE USER FEE ASSESSMENT SYSTEM UNDER § 19-1515 OF THIS TITLE;

(5) FOR A COMMUNITY HEALTH NETWORK WITH A PARTICIPATING HOSPITAL OR LONG-TERM CARE FACILITY, COMPLY WITH THE DATA REQUIREMENTS OF THE MARYLAND HEALTH RESOURCES PLANNING COMMISSION; AND

~~(4)~~ (6) FOR A COMMUNITY HEALTH NETWORK WITH A PARTICIPATING HOSPITAL, COMPLY WITH THE DATA REPORTING REQUIREMENTS OF THE HEALTH SERVICES COST REVIEW COMMISSION FOR THE PURPOSE OF EVALUATING ANY FIXED PRICE PROSPECTIVE PAYMENT ARRANGEMENTS FOR COMPLIANCE WITH THE REQUIREMENTS OF SUBTITLE 2 OF THIS TITLE.

19-2012. FINANCIAL SOLVENCY REQUIREMENTS.

(A) (1) A COMMUNITY HEALTH NETWORK SHALL BE ACTUARIALLY SOUND.

(2) THE SURPLUS THAT THE COMMUNITY HEALTH NETWORK IS REQUIRED TO HAVE SHALL BE PAID IN FULL.

(B) (1) A COMMUNITY HEALTH NETWORK SHALL HAVE AN INITIAL SURPLUS THAT EXCEEDS ITS LIABILITIES BY AT LEAST $1,500,000.

(2) (I) ALL COMMUNITY HEALTH NETWORKS SHALL MAINTAIN A SURPLUS THAT EXCEEDS ITS LIABILITIES IN THE AMOUNT THAT IS AT LEAST EQUAL TO THE GREATER OF $750,000 OR 5% OF THE SUBSCRIPTION CHARGES EARNED DURING THE PRIOR CALENDAR YEAR AS RECORDED IN ITS ANNUAL REPORT FILED WITH THE COMMISSIONER.

(II) THE COMMISSIONER MAY NOT REQUIRE A COMMUNITY HEALTH NETWORK TO MAINTAIN A SURPLUS IN EXCESS OF A VALUE OF $3,000,000.

(C) (1) FOR THE PROTECTION OF THE COMMUNITY HEALTH NETWORK'S ENROLLEES AND CREDITORS, A COMMUNITY HEALTH NETWORK APPLYING FOR A LICENSE TO OPERATE AS A COMMUNITY HEALTH NETWORK UNDER THIS SUBTITLE SHALL DEPOSIT AND MAINTAIN IN TRUST WITH THE STATE TREASURER $100,000 IN CASH OR GOVERNMENT SECURITIES OF THE TYPE DESCRIBED IN § 5-701(B) OF THE INSURANCE ARTICLE.

(2) (I) THE DEPOSITS SHALL BE ACCEPTED AND HELD IN TRUST BY THE STATE TREASURER IN ACCORDANCE WITH THE PROVISIONS OF §§ 5-701 THROUGH 5-709 OF THE INSURANCE ARTICLE.

(II) FOR THE PURPOSE OF APPLYING THIS PARAGRAPH, A COMMUNITY HEALTH NETWORK SHALL BE TREATED AS AN INSURER.

(D) THE COMMISSIONER MAY WAIVE THE SURPLUS AND DEPOSIT REQUIREMENTS CONTAINED IN THIS SECTION IF THE COMMISSIONER IS SATISFIED THAT:

(1) THE COMMUNITY HEALTH NETWORK HAS SUFFICIENT NET WORTH AND AN ADEQUATE HISTORY OF GENERATING NET INCOME TO ASSURE FINANCIAL VIABILITY FOR THE NEXT YEAR;

(2) THE COMMUNITY HEALTH NETWORK'S PERFORMANCE AND OBLIGATIONS ARE GUARANTEED BY ANOTHER PERSON WITH SUFFICIENT NET WORTH AND AN ADEQUATE HISTORY OF GENERATING NET INCOME; OR

(3) THE ASSETS OF THE COMMUNITY HEALTH NETWORK OR CONTRACTS WITH INSURERS, GOVERNMENTAL ENTITIES, PROVIDERS, OR OTHER PERSONS ARE SUFFICIENT TO REASONABLY ASSURE THE PERFORMANCE OF THE COMMUNITY HEALTH NETWORK'S OBLIGATIONS.

(E) (1) THE PROCEDURES FOR OFFERING HEALTH CARE SERVICES AND OFFERING AND TERMINATING CONTRACTS TO ENROLLEES MAY NOT DISCRIMINATE UNFAIRLY ON THE BASIS OF AGE, SEX, RACE, HEALTH, OR ECONOMIC STATUS.

(2) PARAGRAPH (1) OF THIS SUBSECTION DOES NOT PROHIBIT:

(I) REASONABLE UNDERWRITING CLASSIFICATIONS FOR ESTABLISHING CONTRACT RATES; OR

(II) EXPERIENCE RATING.

(F) (1) THE TERMS OF THE AGREEMENTS BETWEEN A COMMUNITY HEALTH NETWORK AND PROVIDERS OF HEALTH CARE SERVICES SHALL CONTAIN A "HOLD HARMLESS" CLAUSE.

(2) THE HOLD HARMLESS CLAUSE SHALL PROVIDE THAT THE HEALTH CARE PROVIDER MAY NOT, UNDER ANY CIRCUMSTANCES, INCLUDING NONPAYMENT OF MONEYS DUE THE PROVIDERS BY THE COMMUNITY HEALTH NETWORK, INSOLVENCY OF THE COMMUNITY HEALTH NETWORK, OR BREACH OF THE PROVIDER CONTRACT, BILL, CHARGE, COLLECT A DEPOSIT, SEEK COMPENSATION, REMUNERATION, OR REIMBURSEMENT FROM, OR HAVE ANY RECOURSE AGAINST THE ENROLLEE, PATIENT, OR ANY PERSONS OTHER THAN THE

COMMUNITY HEALTH NETWORK ACTING ON THEIR BEHALF, FOR HEALTH CARE SERVICES PROVIDED IN ACCORDANCE WITH THE PROVIDER CONTRACT.

(3) COLLECTION FROM THE ENROLLEE OF COPAYMENTS OR SUPPLEMENTAL CHARGES IN ACCORDANCE WITH THE TERMS OF THE ENROLLEE'S CONTRACT WITH THE COMMUNITY HEALTH NETWORK, OR CHARGES FOR HEALTH CARE SERVICES NOT COVERED UNDER THE ENROLLEE'S CONTRACT, MAY BE EXCLUDED FROM THE HOLD HARMLESS CLAUSE.

(4) EACH PROVIDER CONTRACT SHALL STATE THAT THE HOLD HARMLESS CLAUSE WILL SURVIVE THE TERMINATION OF THE PROVIDER CONTRACT, REGARDLESS OF THE CAUSE OF TERMINATION.

(G) A COMMUNITY HEALTH NETWORK SHALL PROVIDE EVIDENCE OF ADEQUATE INSURANCE COVERAGE OR AN ADEQUATE PLAN FOR SELF-INSURANCE TO SATISFY CLAIMS FOR INJURIES THAT MAY OCCUR FROM PROVIDING HEALTH CARE SERVICES.

(H) (1) EXCEPT AS PROVIDED IN PARAGRAPH (3) OF THIS SUBSECTION, AN ENROLLEE OF A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE MAY NOT BE LIABLE TO A HEALTH CARE PROVIDER FOR A COVERED HEALTH CARE SERVICE PROVIDED TO THE ENROLLEE.

(2) (I) A HEALTH CARE PROVIDER OR A REPRESENTATIVE OF A HEALTH CARE PROVIDER MAY NOT COLLECT OR ATTEMPT TO COLLECT FROM AN ENROLLEE MONEY OWED TO THE HEALTH CARE PROVIDER BY A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE.

(II) A HEALTH CARE PROVIDER OR A REPRESENTATIVE OF A HEALTH CARE PROVIDER MAY NOT MAINTAIN AN ACTION AGAINST AN ENROLLEE TO COLLECT OR ATTEMPT TO COLLECT MONEY OWED TO THE HEALTH CARE PROVIDER BY A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE.

(3) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SUBSECTION, A HEALTH CARE PROVIDER OR REPRESENTATIVE OF A HEALTH CARE PROVIDER MAY COLLECT OR ATTEMPT TO COLLECT FROM AN ENROLLEE:

(I) COPAYMENT OR COINSURANCE SUMS OWED BY THE ENROLLEE TO A COMMUNITY HEALTH NETWORK LICENSED UNDER THIS SUBTITLE FOR COVERED HEALTH CARE SERVICES PROVIDED BY THE HEALTH CARE PROVIDER; OR

(II) PAYMENT OR CHARGES FOR HEALTH CARE SERVICES NOT COVERED UNDER THE ENROLLEE'S CONTRACT.

(I) (1) THE COMMISSIONER SHALL REQUIRE EACH COMMUNITY HEALTH NETWORK TO HAVE AN INSOLVENCY PLAN THAT PROVIDES FOR:

(I) CONTINUATION OF BENEFITS TO ENROLLEES FOR THE DURATION OF THE CONTRACT PERIOD FOR WHICH PREMIUMS HAVE BEEN PAID; AND

(II) CONTINUATION OF BENEFITS TO ENROLLEES WHO ARE ADMITTED TO AN INPATIENT HEALTH CARE FACILITY ON THE DATE OF INSOLVENCY UNTIL THE EARLIER OF:

1. THE DISCHARGE OF THE ENROLLEE FROM THE INPATIENT HEALTH CARE FACILITY; OR

2. 365 DAYS.

(2) IN DETERMINING THE ADEQUACY OF AN INSOLVENCY PLAN, THE COMMISSIONER MAY CONSIDER:

(I) THE EXISTENCE OF INSURANCE TO COVER EXPENSES INCURRED IN CONTINUING BENEFITS AFTER AN INSOLVENCY;

(II) PROVISIONS IN PROVIDER CONTRACTS OBLIGATING PROVIDERS TO CONTINUE TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES:

1. FOR THE DURATION OF THE CONTRACT PERIOD FOR WHICH PREMIUMS HAVE BEEN MADE; AND

2. IF ADMITTED TO AN INPATIENT HEALTH CARE FACILITY, UNTIL THE ENROLLEE IS DISCHARGED OR 365 DAYS, WHICHEVER OCCURS FIRST;

(III) RESERVES;

(IV) LETTERS OF CREDIT;

(V) GUARANTEES; OR

(VI) ANY OTHER ARRANGEMENT TO ASSURE THAT BENEFITS ARE CONTINUED IN ACCORDANCE WITH THE PROVISIONS OF PARAGRAPH (1) OF THIS SUBSECTION.

(J) NOTWITHSTANDING ANY OTHER PROVISION OF THIS SECTION, A HOSPITAL EMERGENCY FACILITY MAY COLLECT OR ATTEMPT TO COLLECT PAYMENT FROM AN ENROLLEE FOR HEALTH CARE SERVICES PROVIDED TO THAT ENROLLEE FOR A MEDICAL CONDITION THAT IS DETERMINED NOT TO BE AN EMERGENCY AS DEFINED IN § 19-701(D) OF THIS TITLE.

19-2013. OPEN ENROLLMENT.

EACH COMMUNITY HEALTH NETWORK SHALL PROVIDE TO ANY PERSON DURING ANY OPEN ENROLLMENT PERIOD AND, AT LEAST ANNUALLY, TO EACH ENROLLEE WRITTEN MATERIALS THAT INCLUDE IN CLEAR AND CONCISE TERMS THE FOLLOWING INFORMATION:

(1) ANY COPAYMENT, COINSURANCE, OR DEDUCTIBLE REQUIREMENTS THAT AN ENROLLEE OR DEPENDENT OF AN ENROLLEE MAY INCUR IN OBTAINING COVERAGE AND HEALTH CARE SERVICES UNDER THE COMMUNITY HEALTH NETWORK'S HEALTH BENEFIT PLAN;

(2) THE HEALTH CARE BENEFITS TO WHICH THE ENROLLEE IS ENTITLED;

(3) AN ANNUALLY UPDATED LIST OF ADDRESSES AND TELEPHONE NUMBERS OF HEALTH CARE PROVIDERS PARTICIPATING IN THE COMMUNITY HEALTH NETWORK;

(4) WHERE AND IN WHAT MANNER AN ENROLLEE MAY OBTAIN HEALTH CARE SERVICES, INCLUDING PROCEDURES FOR SELECTING OR CHANGING PRIMARY CARE PHYSICIANS AND THE LOCATIONS OF HOSPITALS AND OUTPATIENT TREATMENT CENTERS THAT ARE UNDER CONTRACT WITH THE COMMUNITY HEALTH NETWORK TO PROVIDE HEALTH CARE SERVICES TO ENROLLEES;

(5) ANY LIMITATIONS OF THE HEALTH CARE SERVICES, KINDS OF SERVICES, BENEFITS, AND EXCLUSIONS THAT APPLY TO THE HEALTH BENEFIT PLAN; AND

(6) GRIEVANCE AND COMPLAINT PROCEDURES FOR CLAIM OR TREATMENT DENIALS, DISSATISFACTION WITH CARE, AND ACCESS TO CARE ISSUES.

19-2014. ENROLLEE COMPLAINT SYSTEM.

(A) EACH COMMUNITY HEALTH NETWORK SHALL ESTABLISH AND MAINTAIN A USER-FRIENDLY ENROLLEE COMPLAINT SYSTEM.

(B) THE COMPLAINT SYSTEM SHALL INCLUDE:

(1) REASONABLE PROCEDURES FOR THE RESOLUTION OF COMPLAINTS INITIATED BY ENROLLEES CONCERNING THE PROVISION OF HEALTH CARE SERVICES; AND

(2) A DISCLOSURE THAT IF A COMPLAINT IS NOT SATISFIED TO THE SATISFACTION OF THE ENROLLEE, THE ENROLLEE MAY CONTACT THE DEPARTMENT IN ACCORDANCE WITH § 19-2006 OF THIS SUBTITLE.

19-2015. LICENSE APPLICATION REQUIREMENTS.

(A) AN APPLICANT FOR A LICENSE TO OPERATE AS A COMMUNITY HEALTH NETWORK SHALL:

(1) SUBMIT AN APPLICATION TO THE SECRETARY;

(2) PAY TO THE SECRETARY THE APPLICATION FEE SET BY THE SECRETARY BY REGULATION; AND

(3) PAY TO THE COMMISSIONER AN APPLICATION REVIEW FEE SET BY THE COMMISSIONER BY REGULATION.

(B) THE APPLICATION SHALL:

(1) BE ON A FORM AND ACCOMPANIED BY THE SUPPORTING INFORMATION THAT THE SECRETARY AND THE COMMISSIONER REQUIRE UNDER SUBSECTION (C) OF THIS SECTION; AND

(2) BE SIGNED AND VERIFIED BY THE APPLICANT.

(C) THE APPLICATION SHALL BE ACCOMPANIED BY:

(1) A COPY OF THE BASIC COMMUNITY HEALTH NETWORK ORGANIZATIONAL DOCUMENT AND ANY AMENDMENTS TO IT THAT, WHERE APPLICABLE, ARE CERTIFIED BY THE DEPARTMENT OF ASSESSMENTS AND TAXATION;

(2) A COPY OF THE BYLAWS OF THE COMMUNITY HEALTH NETWORK, IF ANY, THAT ARE CERTIFIED BY THE APPROPRIATE OFFICER;

(3) A LIST OF THE INDIVIDUALS WHO ARE TO BE RESPONSIBLE FOR THE CONDUCT OF THE AFFAIRS OF THE COMMUNITY HEALTH NETWORK, INCLUDING ALL MEMBERS OF THE GOVERNING BODY, THE OFFICERS AND DIRECTORS IF IT IS A CORPORATION, AND THE PARTNERS OR ASSOCIATES IF IT IS A PARTNERSHIP OR ASSOCIATION;

(4) THE ADDRESSES OF THOSE INDIVIDUALS AND THEIR OFFICIAL CAPACITY WITH THE COMMUNITY HEALTH NETWORK;

(5) A STATEMENT BY EACH INDIVIDUAL REFERRED TO IN ITEM (3) OF THIS SUBSECTION THAT FULLY DISCLOSES THE EXTENT AND NATURE OF ANY CONTRACT OR ARRANGEMENT BETWEEN THE INDIVIDUAL AND THE COMMUNITY HEALTH NETWORK AND ANY POSSIBLE CONFLICT OF INTEREST;

(6) IF APPLICABLE, A RESUME OF THE QUALIFICATIONS OF:

(I) THE ADMINISTRATOR;

(II) THE MEDICAL DIRECTOR;

(III) THE ENROLLMENT DIRECTOR; AND

(IV) ANY OTHER INDIVIDUAL WHO IS ASSOCIATED WITH THE COMMUNITY HEALTH NETWORK THAT THE COMMISSIONER AND THE SECRETARY REQUEST UNDER THEIR JOINT INTERNAL PROCEDURES;

(7) A STATEMENT THAT DESCRIBES GENERALLY:

(I) THE COMMUNITY HEALTH NETWORK, INCLUDING:

1. ITS OPERATIONS;

2. ITS ENROLLMENT PROCESS;

3. ITS QUALITY ASSURANCE MECHANISM; AND

4. ITS INTERNAL GRIEVANCE PROCEDURES;

(II) THE METHODS THE COMMUNITY HEALTH NETWORK PROPOSES TO USE TO OFFER ITS ENROLLEES AND PUBLIC REPRESENTATIVES AN OPPORTUNITY TO PARTICIPATE IN MATTERS OF POLICY AND OPERATION;

(III) THE LOCATION OF THE FACILITIES WHERE HEALTH CARE SERVICES WILL BE AVAILABLE REGULARLY TO ENROLLEES;

(IV) THE TYPE AND SPECIALTY OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS WHO ARE ENGAGED TO PROVIDE HEALTH CARE SERVICES;

(V) THE NUMBER OF PHYSICIANS AND PERSONNEL IN EACH CATEGORY; AND

(VI) THE HEALTH AND MEDICAL RECORDS SYSTEM TO PROVIDE DOCUMENTATION OF USE BY ENROLLEES;

(8) THE FORM OF EACH CONTRACT THAT THE COMMUNITY HEALTH NETWORK PROPOSES TO OFFER TO PURCHASERS SHOWING THE BENEFITS TO WHICH THEY ARE ENTITLED AND A TABLE OF THE RATES CHARGED OR PROPOSED TO BE CHARGED FOR EACH FORM OF CONTRACT;

(9) A STATEMENT THAT DESCRIBES WITH REASONABLE CERTAINTY EACH GEOGRAPHIC AREA TO BE SERVED BY THE COMMUNITY HEALTH NETWORK;

(10) A STATEMENT OF THE FINANCIAL CONDITION OF THE COMMUNITY HEALTH NETWORK, INCLUDING:

(I) SOURCES OF FINANCIAL SUPPORT;

(II) A BALANCE SHEET SHOWING ASSETS, LIABILITIES, AND MINIMUM TANGIBLE NET WORTH; AND

(III) ANY OTHER FINANCIAL INFORMATION THE COMMISSIONER REQUIRES FOR ADEQUATE FINANCIAL EVALUATION;

(11) COPIES OF ANY PROPOSED ADVERTISING AND PROPOSED TECHNIQUES AND METHODS OF SELLING THE SERVICES OF THE COMMUNITY HEALTH NETWORK;

(12) A POWER OF ATTORNEY THAT IS EXECUTED BY THE COMMUNITY HEALTH NETWORK APPOINTING THE COMMISSIONER AS AGENT OF THE ORGANIZATION IN THIS STATE TO ACCEPT SERVICE OF PROCESS IN ANY ACTION, PROCEEDING, OR CAUSE OF ACTION ARISING IN THIS STATE AGAINST THE COMMUNITY HEALTH NETWORK;

(13) COPIES OF THE AGREEMENTS PROPOSED TO BE MADE BETWEEN THE COMMUNITY HEALTH NETWORK AND HEALTH CARE PROVIDERS; AND

(14) ANY OTHER DOCUMENT THAT THE SECRETARY OR THE COMMISSIONER MAY REQUIRE.

19-2016. LICENSE RENEWAL REQUIREMENTS.

(A) A LICENSE EXPIRES ON THE SECOND ANNIVERSARY OF ITS EFFECTIVE DATE UNLESS THE LICENSE IS RENEWED FOR A 2-YEAR TERM AS PROVIDED IN THIS SECTION.

(B) BEFORE THE LICENSE EXPIRES, A LICENSE MAY BE RENEWED FOR AN ADDITIONAL 2-YEAR TERM, IF THE APPLICANT:

(1) OTHERWISE IS ENTITLED TO BE LICENSED;

(2) PAYS TO THE SECRETARY THE RENEWAL FEE SET BY THE SECRETARY BY REGULATION;

(3) PAYS TO THE COMMISSIONER THE RENEWAL REVIEW FEE SET BY THE COMMISSIONER BY REGULATION; AND

(4) SUBMITS TO THE SECRETARY:

(I) A RENEWAL APPLICATION ON THE FORM THAT THE SECRETARY AND COMMISSIONER REQUIRE; AND

(II) SATISFACTORY EVIDENCE OF COMPLIANCE WITH ANY REQUIREMENT UNDER THIS SUBTITLE FOR LICENSE RENEWAL.

(C) THE SECRETARY AND COMMISSIONER SHALL RENEW THE LICENSE IF THE APPLICANT MEETS THE REQUIREMENTS OF THIS SECTION.

(D) THE SECRETARY AND THE COMMISSIONER SHALL SET REASONABLE APPLICATION, APPLICATION REVIEW, LICENSE RENEWAL, AND RENEWAL REVIEW FEES NOT TO EXCEED THE ADMINISTRATIVE COST OF THE LICENSING PROGRAM AND THE COST TO THE SECRETARY AND THE COMMISSIONER FOR CARRYING OUT THEIR RESPONSIBILITIES UNDER THIS SUBTITLE.

19-2017. DENIAL OF LICENSE OR REFUSAL TO RENEW LICENSE.

(A) AS TO ANY MATTER THAT IS WITHIN THE JURISDICTION OF THE SECRETARY OR THE COMMISSIONER UNDER THIS SUBTITLE, THE SECRETARY ~~AND~~ OR THE COMMISSIONER MAY DENY A LICENSE TO ANY APPLICANT OR SUSPEND, RESTRICT, OR REVOKE A LICENSE IF THE APPLICANT OR LICENSEE DOES NOT MEET THE REQUIREMENTS OF THIS SUBTITLE OR ANY REGULATIONS THAT ARE ADOPTED UNDER THIS SUBTITLE.

(B) (1) BEFORE DENYING, SUSPENDING, RESTRICTING, OR REVOKING A LICENSE UNDER THIS SUBTITLE, THE SECRETARY ~~AND~~ OR THE COMMISSIONER, AS APPLICABLE, SHALL PROVIDE THE APPLICANT OR LICENSEE AN OPPORTUNITY FOR A HEARING.

(2) THE SECRETARY ~~AND~~ OR THE COMMISSIONER, AS APPLICABLE, SHALL SEND A HEARING NOTICE TO ANY APPLICANT OR LICENSEE BY CERTIFIED MAIL, RETURN RECEIPT REQUESTED, AT LEAST 30 DAYS BEFORE THE HEARING.

19-2018. RATES AND CONTRACTS.

(A) EACH COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER, BEFORE THEY BECOME EFFECTIVE:

(1) ALL RATES THAT THE COMMUNITY HEALTH NETWORK CHARGES ENROLLEES OR GROUPS OF ENROLLEES; AND

(2) THE FORM AND CONTENT OF EACH CONTRACT BETWEEN THE COMMUNITY HEALTH NETWORK AND ITS ENROLLEES OR GROUPS OF ENROLLEES.

(B) THE FORM AND CONTENT OF EACH CONTRACT FILED UNDER SUBSECTION (A)(2) OF THIS SECTION, INCLUDING EVIDENCE OF COVERAGE OR CERTIFICATE BETWEEN A COMMUNITY HEALTH NETWORK AND ITS ENROLLEES OR GROUPS OF ENROLLEES, SHALL CONTAIN THE SAME PROVISIONS AND OFFERS OF BENEFITS AS REQUIRED OF HEALTH MAINTENANCE ORGANIZATIONS UNDER SUBTITLE 7 OF THIS TITLE.

~~(B)~~ (C) RATES OF A COMMUNITY HEALTH NETWORK MAY NOT BE EXCESSIVE, INADEQUATE, OR UNFAIRLY DISCRIMINATORY IN RELATION TO THE SERVICES OFFERED.

~~(C)~~ (D) (1) IF, AT ANY TIME, A COMMUNITY HEALTH NETWORK WISHES TO AMEND A CONTRACT WITH ITS ENROLLEES OR CHANGE A RATE CHARGED, THE COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER THE NUMBER OF COPIES OF THE AMENDMENT OR RATE CHANGE THAT THE COMMISSIONER REQUIRES.

(2) THE COMMISSIONER SHALL PROVIDE THE DEPARTMENT WITH THE NUMBER OF COPIES IT REQUIRES.

~~(D)~~ (E) UNLESS THE COMMISSIONER DISAPPROVES A FILING UNDER THIS SECTION, THE FILING BECOMES EFFECTIVE 60 DAYS AFTER THE COMMISSIONER RECEIVES THE FILING OR ON ANOTHER DATE THAT THE COMMISSIONER SETS.

19-2018.1.

(A) (1) IN THIS SECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(2) "ADMINISTRATIVE SERVICE PROVIDER CONTRACT" MEANS A CONTRACT OR CAPITATION AGREEMENT BETWEEN A COMMUNITY HEALTH NETWORK AND A CONTRACTING PROVIDER WHICH INCLUDES REQUIREMENTS THAT:

(I) THE CONTRACTING PROVIDER ACCEPT PAYMENTS FROM A COMMUNITY HEALTH NETWORK FOR HEALTH CARE SERVICES TO BE PROVIDED TO ENROLLEES OF THE COMMUNITY HEALTH NETWORK THAT THE CONTRACTING PROVIDER ARRANGES TO BE PROVIDED BY EXTERNAL PROVIDERS; AND

(II) THE CONTRACTING PROVIDER ADMINISTER PAYMENTS PURSUANT TO THE CONTRACT WITHIN THE COMMUNITY HEALTH NETWORK FOR THE HEALTH CARE SERVICES TO THE EXTERNAL PROVIDERS.

(3) "CONTRACTING PROVIDER" MEANS A PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO ENTERS INTO AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT WITH A COMMUNITY HEALTH NETWORK.

(4) "EXTERNAL PROVIDER" MEANS A HEALTH CARE PROVIDER, INCLUDING A PHYSICIAN OR HOSPITAL, WHO IS NOT:

(I) A CONTRACTING PROVIDER; OR

(II) AN EMPLOYEE, SHAREHOLDER, OR PARTNER OF A CONTRACTING PROVIDER.

(B) A COMMUNITY HEALTH NETWORK MAY NOT ENTER INTO AN ADMINISTRATIVE SERVICE PROVIDER CONTRACT UNLESS:

(1) THE COMMUNITY HEALTH NETWORK FILES WITH THE INSURANCE COMMISSIONER A PLAN THAT SATISFIES THE REQUIREMENTS OF SUBSECTION (C) OF THIS SECTION; AND

(2) THE INSURANCE COMMISSIONER DOES NOT DISAPPROVE THE FILING WITHIN 30 DAYS AFTER THE PLAN IS FILED.

(C) THE PLAN REQUIRED UNDER SUBSECTION (B) OF THIS SECTION SHALL:

(1) REQUIRE THE CONTRACTING PROVIDER TO PROVIDE THE COMMUNITY HEALTH NETWORK WITH REGULAR REPORTS, AT LEAST QUARTERLY, THAT IDENTIFY PAYMENTS MADE OR OWED TO EXTERNAL PROVIDERS IN SUFFICIENT DETAIL TO DETERMINE IF THE PAYMENTS ARE BEING MADE IN COMPLIANCE WITH LAW;

(2) REQUIRE THE CONTRACTING PROVIDER TO PROVIDE TO THE COMMUNITY HEALTH NETWORK A CURRENT ANNUAL FINANCIAL STATEMENT OF THE CONTRACTING PROVIDER EACH YEAR;

(3) REQUIRE THE CREATION BY THE CONTRACTING PROVIDER, OR ON THE CONTRACTING PROVIDER'S BEHALF, OF A SEGREGATED FUND (WHICH MAY INCLUDE WITHHELD FUNDS, ESCROW ACCOUNTS, LETTERS OF CREDIT, OR SIMILAR ARRANGEMENTS), OR REQUIRE THE AVAILABILITY OF OTHER RESOURCES THAT ARE SUFFICIENT TO SATISFY THE CONTRACTING PROVIDER'S OBLIGATIONS TO EXTERNAL PROVIDERS FOR SERVICES RENDERED TO ENROLLEES OF THE COMMUNITY HEALTH NETWORK;

(4) REQUIRE AN EXPLANATION OF HOW THE FUND OR RESOURCES REQUIRED UNDER ITEM (3) OF THIS SUBSECTION CREATE FUNDS OR OTHER RESOURCES SUFFICIENT TO SATISFY THE CONTRACTING PROVIDER'S OBLIGATIONS TO EXTERNAL PROVIDERS FOR SERVICES RENDERED TO ENROLLEES OF THE COMMUNITY HEALTH NETWORK; AND

(5) PERMIT THE COMMUNITY HEALTH NETWORK, AT MUTUALLY AGREED UPON TIMES AND UPON REASONABLE PRIOR NOTICE, TO AUDIT AND INSPECT THE CONTRACTING PROVIDER'S BOOKS, RECORDS, AND OPERATIONS RELEVANT TO THE PROVIDER'S CONTRACT FOR THE PURPOSE OF DETERMINING THE CONTRACTING PROVIDER'S COMPLIANCE WITH THE PLAN.

(D) THE COMMUNITY HEALTH NETWORK AND THE CONTRACTING PROVIDER SHALL COMPLY WITH THE PLAN.

(E) (1) THE COMMUNITY HEALTH NETWORK SHALL MONITOR THE CONTRACTING PROVIDER TO ASSURE COMPLIANCE WITH THE PLAN, AND THE HEALTH MAINTENANCE ORGANIZATION SHALL NOTIFY THE CONTRACTING PROVIDER WHENEVER A FAILURE TO COMPLY WITH THE PLAN OCCURS.

(2) UPON THE FAILURE OF THE CONTRACTING PROVIDER TO COMPLY WITH THE PLAN FOLLOWING NOTICE OF NONCOMPLIANCE, OR UPON TERMINATION OF THE ADMINISTRATIVE SERVICE PROVIDER CONTRACT FOR ANY REASON, THE COMMUNITY HEALTH NETWORK SHALL ASSUME THE ADMINISTRATION OF ANY PAYMENTS DUE FROM THE CONTRACTING PROVIDER TO EXTERNAL PROVIDERS ON BEHALF OF THE CONTRACTING PROVIDER.

(F) THE PLAN AND ALL SUPPORTING DOCUMENTATION SUBMITTED IN CONNECTION WITH THE PLAN SHALL BE TREATED AS CONFIDENTIAL AND PROPRIETARY, AND MAY NOT BE DISCLOSED EXCEPT AS OTHERWISE REQUIRED BY LAW.

19-2019. MARKETING DOCUMENTS.

EACH MARKETING DOCUMENT THAT SETS FORTH THE HEALTH CARE SERVICES OF A COMMUNITY HEALTH NETWORK SHALL DESCRIBE FULLY AND CLEARLY:

(1) THE HEALTH CARE SERVICES UNDER EACH BENEFIT PACKAGE AND EVERY OTHER BENEFIT TO WHICH AN ENROLLEE IS ENTITLED;

(2) WHERE AND HOW HEALTH CARE SERVICES MAY BE OBTAINED;

(3) EACH EXCLUSION OR LIMITATION ON ANY HEALTH CARE SERVICE OR OTHER BENEFIT THAT IT PROVIDES;

(4) EACH DEDUCTIBLE FEATURE;

(5) EACH COPAYMENT PROVISION; AND

(6) ALL INFORMATION REQUIRED BY § 15-1206(B) OF THE INSURANCE ARTICLE.

19-2020. FINANCIAL AFFAIRS.

(A) THE COMMISSIONER OR AN AGENT OF THE COMMISSIONER SHALL EXAMINE THE FINANCIAL AFFAIRS AND STATUS OF EACH COMMUNITY HEALTH NETWORK AT LEAST ONCE EVERY 3 YEARS.

(B) (1) IN AN EXAMINATION UNDER SUBSECTION (A) OF THIS SECTION, THE OFFICERS AND EMPLOYEES OF THE COMMUNITY HEALTH NETWORK SHALL:

(I) COOPERATE WITH AND HELP THE COMMISSIONER AND ITS AGENTS; AND

(II) GIVE THEM CONVENIENT ACCESS TO ALL BOOKS, RECORDS, PAPERS, AND DOCUMENTS THAT RELATE TO THE BUSINESS OF THE COMMUNITY HEALTH NETWORK, INCLUDING FINANCIAL RECORDS OF HEALTH CARE PROVIDERS THAT PROVIDE HEALTH CARE SERVICES UNDER CONTRACT.

(2) (I) THE COMMISSIONER MAY EMPLOY EXPERTS, NOT OTHERWISE A PART OF THE STAFF OF THE COMMISSIONER, TO CONDUCT AN EXAMINATION MADE UNDER THIS SECTION AT THE EXPENSE OF THE COMMUNITY HEALTH NETWORK.

(II) AN EXPERT EMPLOYED UNDER THIS PARAGRAPH MAY REWRITE, POST, OR BALANCE THE ACCOUNTS OF A COMMUNITY HEALTH NETWORK BEING EXAMINED.

(C) THE COMMISSIONER MAY EXAMINE UNDER OATH ANY OFFICER, AGENT, EMPLOYEE, OR ENROLLEE OF THE COMMUNITY HEALTH NETWORK, OR ANY OTHER PERSON WHO HAS OR EVER HAD ANY RELATION TO ITS AFFAIRS, TRANSACTIONS, OR FINANCIAL CONDITIONS.

19-2021. ANNUAL REPORTS.

(A) EXCEPT AS PROVIDED IN SUBSECTION (B) OF THIS SECTION AND UNLESS, FOR GOOD CAUSE SHOWN, THE COMMISSIONER EXTENDS THE TIME FOR A REASONABLE PERIOD:

(1) ON OR BEFORE MARCH 1 OF EACH YEAR, EACH COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER A REPORT THAT SHOWS THE FINANCIAL CONDITION OF THE COMMUNITY HEALTH NETWORK ON THE LAST DAY OF THE PRECEDING CALENDAR YEAR AND ANY OTHER INFORMATION THAT THE COMMISSIONER REQUIRES BY REGULATION; AND

(2) ON OR BEFORE JUNE 1 OF EACH YEAR, EACH COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER AN AUDITED FINANCIAL REPORT FOR THE PRECEDING CALENDAR YEAR.

(B) (1) A COMMUNITY HEALTH NETWORK THAT HAS A FISCAL YEAR OTHER THAN THE CALENDAR YEAR MAY REQUEST PERMISSION TO FILE BOTH THE ANNUAL REPORT REQUIRED UNDER SUBSECTION (A)(1) OF THIS SECTION AND THE AUDITED FINANCIAL REPORT REQUIRED UNDER SUBSECTION (A)(2) OF THIS SECTION AT THE END OF ITS FISCAL YEAR RATHER THAN THE PRECEDING CALENDAR YEAR.

(2) IF THE COMMISSIONER GRANTS A REQUEST UNDER PARAGRAPH (1) OF THIS SUBSECTION, THE COMMUNITY HEALTH NETWORK SHALL FILE WITH THE COMMISSIONER:

(I) THE ANNUAL REPORT WITHIN 60 DAYS AFTER THE END OF ITS FISCAL YEAR; AND

(II) THE AUDITED FINANCIAL REPORT WITHIN 150 DAYS AFTER THE END OF ITS FISCAL YEAR.

(C) THE ANNUAL REPORT SHALL:

(1) BE ON THE FORMS THE COMMISSIONER REQUIRES; AND

(2) INCLUDE A DESCRIPTION OF ANY CHANGES IN THE INFORMATION SUBMITTED UNDER § 19-2015 OF THIS SUBTITLE.

(D) THE AUDITED FINANCIAL REPORT SHALL:

(1) BE ON THE FORMS THE COMMISSIONER REQUIRES; AND

(2) BE CERTIFIED BY AN AUDIT OF A CERTIFIED PUBLIC ACCOUNTING FIRM.

(E) EACH FINANCIAL REPORT FILED UNDER THIS SECTION IS A PUBLIC RECORD.

19-2022. SUPERVISION OF COMMUNITY HEALTH NETWORKS.

(A) IF THE SECRETARY OR THE COMMISSIONER DETERMINE THAT A COMMUNITY HEALTH NETWORK IS NOT OPERATING IN COMPLIANCE WITH THE PROVISIONS OF THIS SUBTITLE, THE SECRETARY OR COMMISSIONER SHALL NOTIFY THE DEPARTMENT OR THE ADMINISTRATION, AS APPROPRIATE, OF THAT DETERMINATION, REASONS FOR THE DETERMINATION, AND RECOMMEND METHODS OF CORRECTION, INCLUDING THE RESTRICTION, SUSPENSION, OR REVOCATION OF THE LICENSE OF THE COMMUNITY HEALTH NETWORK.

(B) AFTER NOTIFYING THE DEPARTMENT OR THE ADMINISTRATION, AS APPROPRIATE, UNDER SUBSECTION (A) OF THIS SECTION, THE SECRETARY AND THE COMMISSIONER SHALL MONITOR THE COMMUNITY HEALTH NETWORK ON A CONTINUOUS BASIS UNTIL THE SECRETARY AND THE COMMISSIONER DETERMINE THAT THE COMMUNITY HEALTH NETWORK IS OPERATING IN COMPLIANCE WITH THIS SUBTITLE.

(C) THE PROVISIONS OF TITLE 9, SUBTITLE 2 OF THE INSURANCE ARTICLE AND § 19-706.1 OF THIS TITLE REGARDING REHABILITATION AND LIQUIDATION APPLY TO COMMUNITY HEALTH NETWORKS TO THE SAME EXTENT THAT THESE PROVISIONS APPLY TO HEALTH MAINTENANCE ORGANIZATIONS.

19-2023. APPLICABILITY OF TAX LAWS.

COMMUNITY HEALTH NETWORKS LICENSED UNDER THIS TITLE ARE EXEMPT FROM THE PREMIUM TAX IMPOSED UNDER § 632 OF THE CODE.

19-2024. PROHIBITED ACTS.

(A) A COMMUNITY HEALTH NETWORK MAY NOT:

(1) VIOLATE ANY PROVISION OF THIS SUBTITLE OR ANY REGULATION ADOPTED UNDER IT;

(2) MAKE ANY FALSE STATEMENT WITH RESPECT TO ANY REPORT OR STATEMENT REQUIRED UNDER THIS SUBTITLE;

(3) PREVENT OR ATTEMPT TO PREVENT THE SECRETARY OR THE COMMISSIONER FROM PERFORMING ANY RESPONSIBILITY IMPOSED BY THIS SUBTITLE;

(4) FRAUDULENTLY OBTAIN OR ATTEMPT TO OBTAIN ANY BENEFIT UNDER THIS SUBTITLE; ~~OR~~

(5) FAIL TO PROVIDE SERVICES TO AN ENROLLEE IN A TIMELY MANNER; OR

(6) VIOLATE THE PROVISIONS OF § 19-729 OF THIS TITLE.

(B) IF A COMMUNITY HEALTH NETWORK VIOLATES THIS SECTION, THE SECRETARY OR THE COMMISSIONER MAY PURSUE ANY ONE OR MORE OF THE COURSES OF ACTION DESCRIBED IN § 19-2025 OF THIS SUBTITLE.

19-2025. PENALTIES.

IF ANY PERSON VIOLATES ANY PROVISION OF THIS SUBTITLE, THE SECRETARY OR THE COMMISSIONER MAY:

(1) ISSUE AN ADMINISTRATIVE ORDER THAT REQUIRES A COMMUNITY HEALTH NETWORK TO:

(I) CEASE THE INAPPROPRIATE CONDUCT OR PRACTICES BY IT OR ANY OF THE PERSONNEL EMPLOYED OR ASSOCIATED WITH IT;

(II) FULFILL ITS CONTRACTUAL OBLIGATIONS;

(III) PROVIDE A SERVICE THAT HAS BEEN DENIED IMPROPERLY; ~~OR~~

(IV) TAKE APPROPRIATE STEPS TO RESTORE ITS ABILITY TO PROVIDE A SERVICE THAT IS REQUIRED TO BE PROVIDED UNDER A CONTRACT;

(V) CEASE THE ENROLLMENT OF ANY ADDITIONAL ENROLLEES, EXCEPT NEWBORN CHILDREN AND OTHER NEWLY ACQUIRED DEPENDENTS OF EXISTING ENROLLEES; OR

(VI) CEASE ANY ADVERTISING OR SOLICITATION;

(2) IMPOSE A PENALTY OF NOT MORE THAN $1,000 FOR EACH UNLAWFUL ACT COMMITTED;

(3) RESTRICT, SUSPEND, OR REVOKE THE LICENSE TO OPERATE AS A COMMUNITY HEALTH NETWORK; OR

(4) APPLY TO ANY COURT FOR LEGAL OR EQUITABLE RELIEF CONSIDERED APPROPRIATE BY THE SECRETARY OR THE COMMISSIONER.

19-2026. SHORT TITLE.

THIS SUBTITLE MAY BE CITED AS THE "COMMUNITY HEALTH NETWORK ACT".

Article - Health Occupations

1-302.

(d) The provisions of this section do not apply to:

(1) A health care practitioner when treating a member of a health maintenance organization as defined in § 19-701 of the Health - General Article OR A COMMUNITY HEALTH NETWORK AS DEFINED IN § 19-2001 OF THE HEALTH - GENERAL ARTICLE if the health care practitioner [does not have a beneficial interest in the health care entity] IS REFERRING PATIENTS TO AN AFFILIATED HEALTH CARE PROVIDER OF THE HEALTH MAINTENANCE ORGANIZATION OR COMMUNITY HEALTH NETWORK;

(2) A health care practitioner who refers a patient to another health care practitioner in the same group practice as the referring health care practitioner;

(3) A health care practitioner with a beneficial interest in a health care entity who refers a patient to that health care entity for health care services or tests, if the services or tests are personally performed by or under the direct supervision of the referring health care practitioner;

(4) A health care practitioner who refers in-office ancillary services or tests that are:

(i) Personally furnished by:

1. The referring health care practitioner;

2. A health care practitioner in the same group practice as the referring health care practitioner; or

3. An individual who is employed and personally supervised by the qualified referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner;

(ii) Provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner furnishes services; and

(iii) Billed by:

1. The health care practitioner performing or supervising the services; or

2. A group practice of which the health care practitioner performing or supervising the services is a member;

(5) A health care practitioner who has a beneficial interest in a health care entity if, in accordance with regulations adopted by the Secretary:

(i) The Secretary determines that the health care practitioner's beneficial interest is essential to finance and to provide the health care entity; and

(ii) The Secretary, in conjunction with the Health Resources Planning Commission, determines that the health care entity is needed to ensure appropriate access for the community to the services provided at the health care entity;

(6) A health care practitioner employed or affiliated with a hospital, who refers a patient to a health care entity that is owned or controlled by a hospital or under common ownership or control with a hospital if the health care practitioner does not have a direct beneficial interest in the health care entity;

(7) A health care practitioner or member of a single specialty group practice, including any person employed or affiliated with a hospital, who has a beneficial interest in a health care entity that is owned or controlled by a hospital or under common ownership or control with a hospital if:

(i) The health care practitioner or other member of that single specialty group practice provides the health care services to a patient pursuant to a referral or in accordance with a consultation requested by another health care practitioner who does not have a beneficial interest in the health care entity; or

(ii) The health care practitioner or other member of that single specialty group practice referring a patient to the facility, service, or entity personally performs or supervises the health care service or procedure; or

(8) A health care practitioner with a beneficial interest in, or compensation arrangement with, a hospital or related institution as defined in § 19-301 of the Health - General Article or a facility, service, or other entity that is owned or controlled by a hospital or related institution or under common ownership or control with a hospital or related institution if:

(i) The beneficial interest was held or the compensation arrangement was in existence on January 1, 1993; and

(ii) Thereafter the beneficial interest or compensation arrangement of the health care practitioner does not increase.

14-501.

(a) (1) In this section the following words have the meanings indicated.

(2) (i) "Alternative health care system" means a system of health care delivery other than a hospital or related institution.

(ii) "Alternative health care system" includes:

1. A health maintenance organization;

2. A preferred provider organization;

3. A COMMUNITY HEALTH NETWORK, AS DEFINED IN § 19-2001 OF THE HEALTH - GENERAL ARTICLE;

[3.] 4. An independent practice association; or

[4.] 5. A community health center that is a nonprofit, freestanding ambulatory health care provider governed by a voluntary board of directors and that provides primary health care services to the medically indigent.

(3) "Medical review committee" means a committee or board that:

(i) Is within one of the categories described in subsection (b) of this section; and

(ii) Performs any of the functions listed in subsection (c) of this section.

(b) For purposes of this section, a medical review committee is:

(1) A regulatory board or agency established by State or federal law to license, certify, or discipline any provider of health care;

(2) A committee of the Faculty or any of its component societies or a committee of any other professional society or association composed of providers of health care;

(3) A committee appointed by or established in a local health department for review purposes;

(4) A committee appointed by or established in the Maryland Institute for Emergency Medical Services Systems;

(5) A committee of the medical staff or other committee, including any risk management, credentialing, or utilization review committee established in accordance with § 19-319 of the Health - General Article, of a hospital, related institution, or alternative health care system, if the governing board of the hospital, related institution, or alternative health care system forms and approves the committee or approves the written bylaws under which the committee operates;

(6) Any person, including a professional standard review organization, who contracts with an agency of this State or of the federal government to perform any of the functions listed in subsection (c) of this section;

(7) Any person who contracts with a provider of health care to perform any of those functions listed in subsection (c) of this section that are limited to the review of services provided by the provider of health care;

(8) An organization, established by the Maryland Hospital Association, Inc. and the Faculty, that contracts with a hospital, related institution, or alternative delivery system to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a hospital in meeting the requirements of § 19-319(e) of the Health - General Article;

(9) A committee appointed by or established in an accredited health occupations school; or

(10) An organization described under § 14-501.1 of this subtitle that contracts with a hospital, related institution, or health maintenance organization to:

(i) Assist in performing the functions listed in subsection (c) of this section; or

(ii) Assist a health maintenance organization in meeting the requirements of Title 19, Subtitle 7 of the Health - General Article, the National Committee for Quality Assurance (NCQA), or any other applicable credentialing law or regulation.

(c) For purposes of this section, a medical review committee:

(1) Evaluates and seeks to improve the quality of health care provided by providers of health care;

(2) Evaluates the need for and the level of performance of health care provided by providers of health care;

(3) Evaluates the qualifications, competence, and performance of providers of health care; or

(4) Evaluates and acts on matters that relate to the discipline of any provider of health care.

(d) (1) Except as otherwise provided in this section, the proceedings, records, and files of a medical review committee are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee.

(2) The proceedings, records, and files of a medical review committee are confidential and are not discoverable and are not admissible in evidence in any civil action arising out of matters that are being reviewed and evaluated by the medical review committee if requested by the following:

(i) The Department of Health and Mental Hygiene to ensure compliance with the provisions of § 19-319 of the Health - General Article;

(ii) A health maintenance organization to ensure compliance with the provisions of Title 19, Subtitle 7 of the Health - General Article and applicable regulations; or

(iii) A health maintenance organization to ensure compliance with the National Committee for Quality Assurance (NCQA) credentialing requirements.

SECTION 2. AND BE IT FURTHER ENACTED, That the catchlines contained in this Act are not law and may not be considered to have been enacted as a part of this Act.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 1997.